The Daughters of Charity of St Vincent de Paul

The Marillac

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

The inspection took place on 26th April 2016. The last inspection took place in October 2013 when the service was found compliant in all areas.

The Marillac is a nursing home that provides accommodation, nursing and rehabilitation support for up to 52 people with complex physical and sensory disabilities. On the day of our inspection there were 50 people using the service.

The service had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Risk was not consistently well managed due to poor recording practices which meant that information held in peoples' care plans was not always up to date and did not always reflect their current needs.

There were systems in place to monitor the quality and safety of the service however these systems had not always picked up on areas of concern.

There were suitable arrangements in place for medicines to be stored and administered safely, however the management of topical creams required improvement.

There were sufficient numbers of staff with the relevant skills and knowledge to effectively meet people's needs.

Where people experienced difficulties with decision-making, they were supported appropriately in accordance with current legislation.

The service was meeting the requirements of the Deprivation of Liberty Safeguards (DoLs). Appropriate mental capacity assessments and best interest decisions had been undertaken. This ensured that any decisions taken on behalf of people were in accordance with the Mental Capacity Act (MCA) 2005, DoLs and associated codes of practice.

People were supported to maintain their health as had regular access to wide range of healthcare professionals. A choice of food and drink was available that reflected peoples nutritional needs, and took into account their preferences and any health requirements.

Staff had positive relationships with people who used the services. People's privacy and dignity was respected at all times and people were treated with kindness and respect.

Care was personalised and met people's individual needs and preferences. People, or their representatives, where appropriate, were involved in making decisions about their care and support and felt listened to and included.

People were encouraged to follow their interests including religious practices and beliefs as well as activities they enjoyed and were supported to keep in contact with their family and friends.

The service responded appropriately to complaints and feedback from people who used the service.

There was a registered manager in post who encouraged an open culture and was approachable . Staff enjoyed working at the service and felt that they were included in the running of the home and that their views were valued.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Risks to people were not always managed and communicated well.

People's medicines were managed safely, however improvements were required in relation to administering topical creams.

There were sufficient numbers of suitably recruited staff to meet people's needs and keep them safe.

People were safeguarded from abuse as staff and management were aware of the signs to look for and how to report suspected abuse.

Is the service effective?

Good

The service was effective.

The provider and staff worked within the principles of the MCA to ensure that people were supported to consent and make decisions with their representatives.

Staff were supported and trained to be effective in their role.

People's nutrition and hydration needs were met.

People were supported to maintain good health and wellbeing.

Is the service caring?

Good

The service was caring.

People were treated with dignity and respect.

People were involved in their care, treatment and support and felt listened to.

People's privacy was respected.

People's independence was protected and promoted.

Is the service responsive?

Good

The service was responsive.

Care was personalised and delivered in accordance with people's preferences.

People were supported with opportunities to engage in community activities of their choice.

The complaints procedure was accessible to people and their relatives.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

There were systems in place to monitor quality and safety but these did not always pick up on areas requiring improvement.

There was a registered manager in post who promoted a positive and open culture.

Staff felt supported by the management team.

People and staff were included in the running of the service.

The Marillac

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 22nd April 2016 and was unannounced.

The inspection team was made up two inspectors, a specialist advisor who was a qualified nurse and an expert by experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

As part of the inspection we reviewed various information including the Provider Information Return (PIR). The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed the information we held about the service including safeguarding alerts and statutory notifications which related to the service. Statutory notifications include information about important events which the provider is required to send us by law.

On the day of inspection we spoke with the registered manager, three unit managers and ten members of staff and two volunteers. We spoke with seven people and four relatives. Where people at the service had complex needs and were not always able to verbally talk with us, or chose not to, we used observation as a tool to gather evidence of people's experiences of the service. We reviewed seven care records, six staff files as well as looking at other relevant documentation such as training records, audits and minutes of meetings.

Requires Improvement

Is the service safe?

Our findings

We spoke with people and their relatives who used the service who told us they felt safe. One relative said, "I have no hesitation in saying people are safe here."

Despite this positive feedback, we found that risks to people were not consistently well documented or communicated between staff. Care records including risk assessments were reviewed monthly however we found some instances where the paper records were not up to date or completed correctly and therefore did not always reflect people's current needs or the actual support being provided by staff. For example, we saw evidence that whilst risk assessments that had been signed to indicate they had been reviewed monthly this had not always happened in practice. Where risk assessments were reviewed, the updated information was not always shared with the relevant staff. For example, a person told us that they had been waiting for a risk assessment to be completed to enable them to go out independently. We found that this risk assessment had been completed but the information had not been communicated to the relevant staff. This meant that the person had experienced unnecessary restrictions placed on their independence.

We found that where people were considered at risk of developing pressure ulcers their care plans stated that they required repositioning every two hours but this was not always recorded as having been completed as there were no turning charts in place. However staff and relatives told us that people were repositioned regularly when required. Staff said that decisions to reposition people were based on clinical need rather than being based on assessments alone and that if a person became unwell then a turning chart would be put in place for recording purposes. There were no incidents of reported pressure ulcers at the time of our inspection indicating that whilst record keeping was poor, people were receiving good quality pressure care.

Despite poor recording practices we found no evidence of a negative impact on the care people received when they were supported by regular staff who knew them well. However when care was provided by agency staff who were unfamiliar with people's complex needs relatives had voiced concerns around how risks were managed and communicated. We spoke with the registered manager about these concerns who advised us the use of agency staff was kept to the minimum to cover unforeseen circumstances such as staff sickness or an increase in people's need. Our observations on the day and discussions with staff confirmed this was the case. People and family members we spoke with told us that they felt that generally there were enough staff though they would like more at night. For example one relative told us that they would stay with their family member until late every night to ensure their needs were met safely overnight.

There were systems in place to manage people's medicines safely. Staff confirmed and we saw evidence that only the senior staff who had been trained and assessed as competent administered people's medicines. Medicine administration records (MAR) had been completed correctly with no gaps evidencing that people received their medicines as required. Topical creams were recorded on people's MAR sheets as being designated to a care worker to administer. A separate treatment sheet was then used for recording when creams had been administered by the care staff. However we found inconsistencies between what was recorded on people's MAR sheet compared to what was recorded on the treatment sheet which meant

we could not be sure that people always had their creams applied as prescribed.

Each unit had its own manager who was responsible for auditing medication. We spoke with a unit manager who advised that they audited the MAR charts weekly to check for any errors and that controlled drugs were checked twice a day. If errors were noted this would trigger a supervision with the person concerned and if appropriate refresher training and competency checks would be completed. We saw supervision notes which confirmed that this had happened.

People's medicines and creams were stored safely in a cupboard in people's bedrooms with surplus medicines kept securely in a cupboard within a locked room.
Medicines for disposal were double checked by two people. There were appropriate and secure facilities to store medicines that required specific storage, for example, controlled drugs and refrigerators for medicines that needed to be stored in controlled temperatures.

Medicines were given to people in an appropriate way. We observed nurses carrying out the medicine round and they were competent at administrating people's medicine. However whilst the service employed the red tabard (do not disturb) system whilst administering medicines. Only one in five of the nurses we saw wore the tabard.

Staff told us that people had regular reviews of their medicines when consultants visited. However we were unable to find any written evidence of medicine reviews in the care records or medical notes to inform staff that these had occurred.

There were systems in place to protect people from abuse and potential harm. Staff were clear about what constituted abuse and understood the need to report concerns and knew how to do this. They told us they had undertaken training in safeguarding and were encouraged to raise concerns.

Staff were aware of the process for reporting accidents and incidents. These were logged with the registered manager and the information shared with a health and safety committee made up of staff members who met monthly to analyse events and learn from them and share information to improve people's safety. For example where it was recorded that a fish bone was found in a person's meal, an email had been circulated to staff asking them to be vigilant at meal times if fish was served.

We found that staff were recruited safely. Checks on the recruitment files for six members of staff evidenced they had completed an application form, provided proof of identity and satisfactory references were obtained. The provider had also undertaken a Disclosure and Barring Service (DBS) check on all staff before they started work. The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with vulnerable adults.

Good

Is the service effective?

Our findings

People who used the service told us they were happy with the care and support they received. One family member said, "The day staff are faultless". Another said, "You should congratulate all the staff." Relatives told us they felt that the permanent staff had the skills and experience to support their family members effectively. However when people were supported by agency staff covering night shifts who did not know them so well they felt this impacted on the effectiveness of the service received.

Staff said that they were provided with an induction before starting work followed by ongoing training which provided them with the skills and knowledge to care for people effectively. Staff were positive about the training they had received which was a mixture of on-line and classroom based learning.

In addition to mandatory training, the service supported staff to continue to learn and develop by providing specialist training opportunities that met the specific needs of the people who used the service. For example, some people who used the service required support to manage their 'tracheostomy'. A tracheostomy is a tube inserted through an incision in a person's throat to help them breathe. This can cause them difficulties with talking, eating, exercise and keeping the tube clean and free of blockage. In response to this identified need the service had organised training for staff in 'tracheostomy care' so that they could support people safely and effectively.

The service used an in-house trainer who was a member of staff to deliver training in moving and positioning people. The trainer assessed the competency of new staff before signing them off. Staff told us that this training was good as they had access to the trainer if they needed any additional help or advice. This meant that people were supported by staff who had the necessary skills to move and position them in a competent manner. We observed staff interactions with people, for example when moving and positioning them or helping them to eat and drink. We saw that they had a good awareness of people's requirements and were able to demonstrate that they understood how to provide appropriate care and support to meet their needs effectively. For example we saw a member of staff applying vaseline to a person's lips after supporting them with eating and drinking to ensure that their skin did not get sore and that they were comfortable and pain free.

Staff told us they received regular supervision which they found useful as a tool for learning and development. One staff member told us, "It's a positive experience, it keeps me on my toes, they ask me questions and challenge me using my concerns as a learning experience." We saw supervision records which demonstrated how supervision was used to learn from mistakes and develop action plans. For example where it was identified that a person had made an error with medication. This resulted in an additional one to one supervision session which included a discussion around medication policies and procedures and the need for a competency assessment.

In addition to individual supervision sessions we saw that group supervisions were also organised in response to specific learning needs being identified. A unit manager told us that if a new person came onto their unit they would find out information about the person's condition and share this knowledge with staff

in group supervision which would be used as a teaching session. This meant that new people coming into the service were supported by staff who were aware of their potential difficulties so better able to meet their needs.

Staff also received annual appraisals which were used to identify training needs, future goals and objectives and highlight any areas which required further development or improvement.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Act. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the Act, and whether conditions on authorisations to deprive a person of their liberty were being met.

Staff told us they had received training in the MCA and training records confirmed this. We found completed mental capacity assessments in people's care plans which had involved family members and other professionals. Staff were able to demonstrate how they applied the principles of the Act in their daily practice to support people who had difficulty making decisions by giving them choices and communicating in ways that helped people to understand what was being asked of them. One staff member told us, "If people don't have capacity we will try to give them the information in a way they will understand to support them to make a decision." The people and relatives we spoke with said that staff always asked permission before providing any care or support and we observed this in practice.

Where people's freedom was restricted there were applications or completed assessments under DoLS in the care plans we looked at. The registered manager understood when an application should be made and how to submit one. We found the home to be meeting the requirements of the Deprivation of Liberty Safeguards which meant that people's rights were protected.

People were supported to have enough to eat and drink. A record was kept of people's weight and this was sent to the GP to review every month to monitor their health. People told us they liked the food and could have drinks whenever they liked. Comments included, "The food is excellent." "It's a good menu to choose from." And, "They are very good at finding alternatives If you don't like your choice." We saw there was a choice of three different main meals including a vegetarian option. If people didn't like the choices on offer they could have something else such as a jacket potato, sandwich or omelette.

We observed the lunch time dining experience for people. The atmosphere was calm and relaxed with music playing in the background. Staff provided one to one assistance to help people to eat. We saw that tables were presented nicely with tablecloths. Adapted equipment was in place where required to support people to eat and drink such as padded trays and tables of varying heights. People were given a choice of utensils to use and asked if they had a preference. Staff spoke to people throughout the meal whilst supporting them to eat and sat at eye level so they could maintain face to face contact.

Of particular note, we observed a speech and language therapist was present during the mealtime, offering advice and support to ensure people could eat and drink safely. We saw that people who were unable to eat and drink were supported with nutrition via a feeding tube by skilled staff who had received the appropriate

training.

People were supported to maintain their health through access to a range of healthcare services including the optician, dentist and chiropodist. We saw that care plans included consent to health care forms which had been signed by people or their representatives. The service had organised regular GP clinics twice weekly and people could ask to see the GP if required. Once a week the GP reviewed people's medicines. In addition a consultant neurologist visited on a monthly basis.

People who lived at the service benefitted from access to in-house therapy services. This included physiotherapy, occupational therapy and speech and language therapy to support people to maintain their health and provide rehabilitation services. People and their relatives also had access to an in-house psychologist to support their emotional wellbeing.

Good

Is the service caring?

Our findings

People and relatives told us the staff were kind and caring. One relative said, "The care is second to none, it's like a second home to me."

The registered manager advised that mandatory dignity workshops had been introduced to ensure people were treated respectfully. People and their relatives said they were treated with dignity and respect and spoken to with courtesy. Staff knew the people they cared for well and spoke about them in a kind and sensitive manner. Care was seen being delivered at a relaxed pace and was not rushed.

Staff understood how to promote and respect people's privacy and dignity, and why this was important. A person told us, "They do respect my dignity and privacy, I am a [professional person] so I know my rights." Staff responses to our questions demonstrated positive values such as knocking on doors before entering, ensuring curtains were drawn, covering people up to protect their modesty when providing personal care and providing any personal support in private.

The registered manager told us that the service provided transport for people to use which had no logos or signage on them to avoid an institutional approach on days out to promote people's dignity. Staff accompanied people on days out with funds made available so that they could join people in meals at cafes or restaurants to promote a normal lifestyle.

The service promoted people's independence as far as possible by allowing people to maintain their routines and exercise choice and control. Staff were familiar with people's preferences and listened to what they wanted. One staff member said, "[Person] is an early riser, we support what they want to do as it's their choice." A person told us, "I can have a lie in if I want, I'm not rushed to get up, I don't have a bad word to say about the place." Another person said, "They do listen to how I want things done, at first they didn't but now they are doing well."

People with complex communication needs were seen daily by the speech and language therapist. Various methods of communication were used so that people could be included in their care and support planning and feel listened to, for example the eye gaze communication system which provided a way for people who were unable to express themselves verbally to communicate and interact with the world.

Staff had received training to support people at the end of their life, for example 'syringe driver' training so that they could administer palliative care medicines. Pastoral care was available for people and their relatives to provide emotional and spiritual support if required.

Good

Is the service responsive?

Our findings

We found that the service was responsive to people's needs, providing a range of therapeutic services to promote health and wellbeing. A relative we spoke with told us, "When my [family member] came here they weren't very responsive, now they are talking, eating and their memory is getting better."

People had care and support plans which described how their needs should be met. We saw two examples of care records relating to people's continence care which were out of date and inaccurate. However, whilst the written records were not always up to date, staff we spoke with were able to demonstrate that they knew the people they cared for well and were aware their specific needs and how to meet them.

People and their relatives told us that they were included in the care and support people received from the service. One relative told us, "I feel like part of the family."
Relatives had contributed information to the care plans which provided staff with knowledge about people's life experience, hobbies, interests, preferences and aspirations. Staff we spoke with demonstrated a good knowledge of people's life stories and used this knowledge to engage with them in meaningful ways.

Relatives were supported to be actively involved in providing care and support to their family members. For example, one family was provided with training by the service in how to support their relative with eating and drinking safely so that they could take the person home at weekends. Friends and relatives were able to visit the service any time and were supported to take people out and about. The support provided included staff assistance during outings and use of the providers transport. In this way people were helped to maintain relationships that were important to them.

The service provided care which was person-centred, which meant that the support was tailored around people's needs rather than the needs of the service. For example people were provided with three custom made slings for their own personal use rather than having to share this equipment with others. This supported people's comfort, dignity and safety. We found that people were supported to maintain routines of their choosing. They told us they were to be able to get up when they wanted to and do what they wanted to do. We spoke to staff about their understanding of providing person-centred care. They told us, "It means putting people first," "It's all about them, about what people want." And, "We don't change things to suit the service."

The building had a large central communal area which was known as 'The Street'. This was a place where people and their family and friends would congregate to enjoy a wide range of activities, and social events throughout the year. We saw a programme of upcoming events to be held on the street which included entertainment provided by singers, live bands and canine performers.

The service also provided a comprehensive in-house activity programme organised by staff and volunteers which included activities such as cookery, bingo, art, reading and music. People were positive about the activities on offer. Two people told us that they loved the activities, in particular the cookery class. A relative told us, "[Person] is invited to everything, their favourite is with the young volunteers who run the bowls in

the street, they really look forward to it, there is also an art workshop which they really like."

We spoke with a volunteer who was running the cookery group. They explained how they adapted the activity to meet people's needs, for example working out precise measurements and using sugar alternatives to support people with diabetes to be able to eat the food they had cooked. The volunteer told us that they liaised with each unit to advise what activities were happening and who might enjoy attending to ensure that everybody who wanted to had a chance to participate. Activities were planned on the basis of feedback obtained from people via a survey that was completed at the beginning of the year.

People were supported to follow their own spiritual and cultural beliefs and practices. We saw that the service had organised a Diwali summer festival in 'The Street' where families had brought in in special food to celebrate their culture. The service had its own chapel which although furnished in the Catholic tradition provided a prayer space for people of all faiths and none. Mass was held every day and the service also provided funerals for people on site. A relative told us, "[Person] is catholic so this is the perfect place for us, [Person] is going on a trip to Lourdes from here."

The service had a complaints policy in place which detailed how people could make a complaint including where and how to escalate concerns if people felt their complaint was not being dealt with appropriately. When people joined the service they received a service-user guide which included information on the complaints process. The registered manager advised us that they had no formal complaints open as it was the service's practice to deal with people's concerns as they arose which meant that most complaints were dealt with on an informal basis. We saw documentation between the manager and a person who had raised concerns. The tone of the communication from the service was conciliatory and pro-active in trying to resolve the issue and the person was invited to meet with the manager to talk things through. We spoke with a relative who told us they had made a complaint. They said, "Our complaint was dealt with appropriately even if it wasn't solved to our complete satisfaction, we feel listened to although nothing changed."

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager in post who understood their registration requirements including notifying us of any significant events to help us monitor how the service kept people safe. Staff told us the registered manager was a good leader and someone who would listen and take action. For example, a unit manager described a situation when they needed additional support for people. They told us, "I went to the manager and said I need extra nurses, they said no problem and let me put one to one support in place."

The service promoted a positive culture that was open and transparent. The registered manager was open about the difficulties the service had recently experienced. They told us that the service was in the process of implementing a new electronic care recording system and there had been unavoidable delays which had contributed to the fact that documentation was in a state of flux. Consequently, some of the paper records in people's care plans had not been completed or updated and did not reflect people's current needs which could potentially place them at risk. We saw that the service had completed audits of the care & support plans however this process had failed to pick up on some of the concerns we had found. That said, the fact that people's care records were not always of an acceptable standard had been recognised by the management team and steps had been taken to rectify the situation. One unit manager told us, "I know the recording is currently very poor, we are dealing with this in supervision." After the inspection we spoke with the registered manager who advised that they were aiming to get the new electronic system on line by the end of June 2016.

The manager informed us that the service had an 'open door' policy and this was confirmed through feedback we received from people and staff who told us the management team were approachable and accessible. Staff were aware of the whistle-blowing policy and procedures and told us they would feel confident to whistle-blow if necessary and felt they would be listened to and their concerns actioned.

The registered manager, supported by the management team and other staff including a maintenance team, undertook regular audits to support people's health and safety. These included food safety, health and safety of the premises and equipment, evacuation and fire drills. Head of department and senior manager meetings were also held regularly which looked at the daily running of the service to monitor the quality of the service provision. We saw minutes of the meetings which showed that action points had been raised and issues addressed.

Checks on the competency of staff to carry out their duties such as the administering of medicines were completed so that people were kept safe. The registered manager also audited staff annual appraisals. This was used as a method to familiarise themselves with staff, monitor their performance and meet their professional needs. For example, the manager had noticed that a member of staff had expressed an interest in learning more about end of life so had arranged for them to join a working party in their field of interest.

The service was supported by a volunteer group 'Friends of the Marillac' who organised events and fundraising to improve the quality of life for people who used the service. Volunteers also played an active part in the day to day running of the service as were responsible for running the comprehensive activity

programme.

Staff were included in the running of the service through regular staff meetings which were held on each unit. We looked at the minutes of staff meetings and saw that they were used constructively to share information and where action points were raised a worker was identified to take responsibility for the actions to ensure issues were dealt with. Care staff on each unit were given additional designated responsibilities for example in health and safety or stock control to promote professional development and team building.

We found that people who used the service or their representatives were asked for their views via an annual quality survey to collect feedback about the service. The results obtained were used to drive improvements. For example, where people and relatives had provided feedback that communication with the service was sometimes difficult and frustrating. In response the service had appointed a family liaison person as a first point of contact so that people knew they always had someone they could speak to. The service had also introduced a monthly newsletter as a way of keeping people and their relatives informed of what was happening within the organisation.

Residents meetings chaired by relatives were held regularly on each unit as a further means of asking people and their families for their opinions and input into the running of the service. Minutes of the meetings were passed on to the member of staff responsible for family liaison to ensure that feedback was considered and actioned by the service. In addition to the group meetings one to one sessions were available for people if they needed any additional communication time with the management team.